STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	04/05/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHURCH OF GOD HOME INC STATE LICENSE NUMBER: **291602**	**801 NORTH HANOVER STREET** **CARLISLE, PA 17013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on April 5, 2023, it was determined that Church of God Home was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0000		
F 0558 SS=D		F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. Call bells for all affected residents were placed within reach. 2. All residents have the potential to be affected by deficient practice. Initial audit of all resident call bells to be conducted. 3. All staff to be educated on call bell policy. 4. Nursing Home Administrator or Designee will audit all call bells 3x per week for two weeks, then 2x per week for two weeks. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0558 SS=D	Continued from page 2 Based on clinical record review, observations, and resident and staff interview, it was determined that the facility failed to ensure that resident needs were accommodated regarding call bell accessibility for two of 20 residents (Residents 6 and 35). Findings include: Review of Resident 6's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and osteoarthritis (degeneration of joint cartilage and the underlying bone). Review of Resident 6's care plan revealed an intervention of: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Observation on April 2, 2023, at 12:30 PM, in Resident 6's room, the call bell was on the floor and	F 0558		

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F 0558 SS=D	Continued from page 3 out of reach of the Resident. Observation with Employee 3 on April 2, 2023, at 12:40 PM, in Resident 6's room, the call bell was on the floor and out of reach of the Resident. Interview with Employee 3 on April 2, 2023, at 12:40 PM, it was revealed that the call bell should be in reach of the Resident. It was also noted that the Resident can use it, however, usually calls out when he needs assistance. Interview with the Nursing Home Administrator (NHA) on April 4, 2023, at 12:40 PM, to inform of the concern with the call bell out of Resident's reach, no further information was provided. Review of Resident 35's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and unspecified sequelae of cerebral infarction (after effects of a stroke; a stroke occurs when something blocks	F 0558		

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F 0558 SS=D	Continued from page 4 blood flow to the brain or when a blood vessel in the brain bursts). Review of Resident 35's care plan revealed an intervention of: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Observation of Resident 35 on April 2, 2023, at 11:19 AM, revealed their call bell laying on the floor. Resident 35 was in bed. Observation of Resident 35 on April 3, 2023, at 10:05 AM, revealed their call bell laying on the floor. Resident 35 was in bed. Observation of Resident 35 on April 5, 2023, at 9:44 AM, revealed that staff were leaving the room and had just finished transferring Resident 35 from their bed to their wheelchair. The call bell was noted to be on the floor, behind the wheelchair. Resident 35 stated, "it's usually on the floor." Observation	F 0558		

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F 0558 SS=D	Continued from page 5 was immediately shown to Employee 3, who indicated that the call bell should have placed in Resident 35's reach when they were gotten up. Employee 2 further indicated that they were not assigned to this Resident today. Employee 3 did place call bell within reach of Resident 35. During an interview with the NHA and Director of Nursing on April 5, 2023, at 11:40 AM, the NHA confirmed that the call bell should have been placed within Resident 35's reach. 28 Pa code 201.29(d) - Resident Rights 28 Pa Code 211.12(d)(1) Nursing Services	F 0558		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 6 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Floor mats of affected residents were replaced. 2. All residents with floor mats have the potential to be affected by deficient practice. Initial audit of all floor mats to be conducted. 3. Housekeeping staff to be educated on maintenance of floor mats. 4. DON or designee will audit all floor mats 2x per week for two weeks then weekly for two weeks. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0584 SS=D	Continued from page 7 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 8 Based on observations, clinical record review, and staff interview, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of 20 residents reviewed (Resident 24). Findings include: Review of Resident 24's clinical record revealed diagnoses that included: dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), atrial fibrillation (an irregular, often rapid heart rate causing poor blood flow), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Observation in Resident 24's room on April 2, 2023, at 1:07 PM, there were was a fall mat on the floor to each side of the bed. Both mats contained several spots of a light brown, dried liquid and had a white film. The fall mat on the window side of bed	F 0584		

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F 0584 SS=D	Continued from page 9 the coating was torn on the bottom right and top right corners, causing the foam to be exposed. Interview on April 2, 2023, at 1:30 PM, with Employee 3 revealed that housekeeping is responsible for cleaning and replacing the floor mats, and the mats are replaced as needed. Interview on April 5, 2023, at 9:10AM with the Nursing Home Administrator (NHA) revealed that housekeeping cleans the floor mats, and any staff member can put in a work order to have the floor mats replaced. It was also revealed that there are floor mats in-house, and that NHA submitted a work order to replace Resident 24's floor mats. 28 Pa. code 201.18(b)(3) Management	F 0584		
F 0637 SS=D		F 0637		

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F 0637 SS=D	Continued from page 10 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	1. Resident #42 MDS assessment corrected to reflect significant change. 2. All residents have the potential to be affected by deficient practice. Initial audit of all residents with significant change of condition in the past 30 days to be conducted. 3. RNACs and LPNACs to be re-educated on completion of significant change assessments. 4. Corporate RNAC or Designee will review all resident significant changes in clinical meeting 3x per week x four (4) weeks for compliance. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0637 SS=D	Continued from page 11 Based on clinical record review and staff interview, it was determined the facility failed to complete a comprehensive assessment after a significant change in condition for one of 20 residents reviewed (Resident 42). Findings include: Review of Resident 42's clinical record revealed diagnoses that included Alzheimer's Disease and hypertension (elevated blood pressure). Review of Resident 42's nursing progress notes revealed a note dated August 24, 2022, that Resident 42 would be discharged from hospice on August 31, 2022, due to no longer meeting the hospice requirements. Review of an additional nursing progress note, dated August 31, 2022, revealed a new order for Resident 42 to discharge from hospice effective August 31, 2022.	F 0637		

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F 0637 SS=D	Continued from page 12 Review of Resident 42's MDS assessments (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs), revealed that a significant change MDS was not completed when Resident 42 was discharged from hospice. During an interview with Employee 2 (Corporate Registered Nurse Assessment Coordinator), on April 5, 2023, at 10:30 AM, she stated that a significant change MDS should have been completed when Resident 42 was discharged from hospice. On April 5, 2023, at 11:35 AM, the Nursing Home Administrator was made aware that Resident 42 did not have a significant change MDS assessment done after being discharged from hospice and of the interview with Employee 2, stating that one should have been done. No additional information was provided. 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0637		

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F 0641 SS=E	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. MDS Assessments corrected for all affected residents. 2. All residents have the potential to be affected by deficient practice. Initial audit of all comprehensive assessments in the past 30 days to be conducted. 3. RNACs and LPNACs to be re-educated on accuracy of assessments. 4. Corporate RNAC or Designee will conduct 10 random assessments (7 quarterly, 1 comprehensive, 2 discharge) per week for two weeks then five random assessments (3 quarterly, 1 comprehensive, 1 discharge) per week for two weeks of sections M, N, O, I, M0100A for compliance. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0641 SS=E	Continued from page 14 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for eight of 20 residents reviewed (Resident 6, 16, 19, 42, 45, 50, 58, and 65). Findings include: Review of Resident 6's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and osteoarthritis (degeneration of joint cartilage and the underlying bone). Observation in Resident 6's room on April 2, 2023, at 12:13 PM, revealed the Resident wearing oxygen running at 3 liters/minute (unit of measure). Review of Resident 6's physician orders the current electronic medical record revealed: oxygen at 3 Liters per minute via nasal cannula every shift, with a	F 0641		

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F 0641 SS=E	Continued from page 15 start date of March 9, 2023; oxygen tubing and humidifier changed every night shift every Monday, with a start date of March 13, 2023; oxygen tubing change weekly every night shift every Sunday, with a start date of April 2, 20/2/23. Further review of Resident 6's clinical record reveled they have been using oxygen since August 24, 2022; and physician orders included to change oxygen tubing and canister every week. Review of Resident 6's quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) with the assessment reference date (last day of the assessment period) of October 21, 2022, failed to document the use of oxygen. Interview on April 5, 2023, at 10:35 AM, with Employee 2 (Corporate Registered Nurse Assessment Coordinator), revealed that Resident 6's quarterly MDS dated October 21, 2022, should've been documented for oxygen use.	F 0641		

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F 0641 SS=E	Continued from page 16 Interview on April 5, 2023, at 11:30 AM, the Nursing Home Administrator (NHA) was informed of the concern regarding the lack of documentation for oxygen use on Resident 6's October 21, 2022, quarterly MDS. No additional information was provided. Review of Resident 16's clinical record revealed diagnoses that included: dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), depression (feelings of severe despondency and dejection), anxiety (a feeling of worry, nervousness, or unease), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), moderate protein calorie malnutrition (low body weight), and pain. Review of Resident 16's quarterly MDS dated January 13, 2023, documented transfer status as extensive assistance with assistance of two staff	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: __00_____ B. WING: _____	04/05/2023

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F 0641 SS=E	Continued from page 17 members. Review of Resident 16's annual MDS dated October 21, 2022, documented transfer status as supervision with assistance of two staff members. Review of Resident 16's care plan and physician orders documented transfer status as use of a Hoyer lift (a sling type lift) with assistance of two staff members. Interview with the NHA on April 4, 2022, at 1:10 PM, revealed the Resident 16 requires the use of a Hoyer lift. Email communication with the NHA on April 4, 2023, at 7:31 PM, documented that Resident 16 is total assistance of two or more for transfers. It was also revealed that the quarterly MDS dated January 13, 2023, and the annual MDS dated October 21, 2022, documented transfer status incorrectly. Review of Resident 19's clinical record revealed	F 0641		

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F 0641 SS=E	Continued from page 18 diagnoses that included a nondisplaced fracture (a break in the bone when the bone fragments are not out of place) of the medial malleolus of right tibia (right ankle) and laceration without foreign body of the right lower leg. Further review of Resident 19's clinical record revealed an admission note dated February 21, 2023, at 5:54 PM, that stated in part that Resident 19 had a cast on their right ankle. Review of Resident 19's Comprehensive Admission MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) with the assessment reference date (last day of the assessment period) of February 28, 2023, revealed in Section M Skin Conditions failed to include the presence of a non-removable device (cast). During an interview with Employee 2 (Corporate Registered Nurse Assessment Coordinator), on April 5, 2023, at 10:33 AM, Employee 2 confirmed	F 0641		

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F 0641 SS=E	Continued from page 19 that there was an error in coding and that the cast should have been coded as a non-removable device. Review of Resident 42's clinical record revealed diagnoses that included Alzheimer's Disease, hypertension (elevated blood pressure), and pressure ulcer to right heel (injury to skin and underlying tissue resulting from prolonged pressure on the skin). Review of Resident 42's wound consult, dated March 6, 2023, revealed Resident 42 has an unstageable pressure ulcer to the right heel. Review of Resident 42's quarterly MDS assessment, dated March 17, 2023, revealed that Section M0100A, is coded "no" to "Resident has a pressure ulcer/injury..." Further review of the MDS revealed M0210, "Does this resident have one or more unhealed pressure ulcer/injuries", is coded as "yes". The MDS is also coded that Resident 42 has one stage 2 pressure ulcer and zero unstageable	F 0641		

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F 0641 SS=E	Continued from page 20 pressure ulcers. During an interview with Employee 2, on April 5, 2023, at 10:30 AM, she stated that M0100A was incorrectly coded. Employee 2 also stated that Resident 42's pressure ulcer was previously a Stage 2 and was reclassified as unstageable. She stated the wound consult from March 6, 2023, was not uploaded into the Resident's electronic clinical record until after the March 17, 2023, MDS was completed. Therefore, the MDS was coded based on the prior documentation, not the most recent, which was documented as an unstageable pressure ulcer. On April 5, 2023, at 11:35 AM, the NHA was made aware of Resident 42's MDS coding errors based on the interview with Employee 2. No additional information was provided. Review of Resident 45's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep) and	F 0641		

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F 0641 SS=E	Continued from page 21 heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 45's physician orders for Continuous Positive Airway Pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while one sleeps) continue with current settings at 8.0 dated March 9, 2023. Further review of Resident 45's clinical record revealed that Resident 45 had been using the CPAP since May 24, 2022. Review of Resident 45's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) with the assessment reference date (last day of the assessment period) of July 22, 2022, revealed that the use of the CPAP was not included in Section O Special Treatments, Procedures and Programs. Review of Resident 45's Quarterly MDS (Minimum	F 0641		

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F 0641 SS=E	Continued from page 22 Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) with the assessment reference date (last day of the assessment period) of October 14, 2022, revealed that the use of the CPAP was not included in Section O Special Treatments, Procedures and Programs. Review of Resident 45's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of January 6, 2023, revealed that the use of the CPAP was documented as a ventilator (a machine or device used medially to support or replace the breathing of a person who is ill, injured, or under anesthesia) in Section O Special Treatments, Procedures and Programs. During an interview with Employee 2, on April 5, 2023, at 10:39 AM, Employee 2 confirmed that all	F 0641		

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F 0641 SS=E	Continued from page 23 these assessments were coded inaccurately. Review of Resident 50's clinical record revealed diagnoses that included dementia and atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls). Review of Resident 50's quarterly MDS, dated January 13, 2023, revealed in Section I, Resident 50 is coded as having a diagnosis of Schizophrenia. Review of Resident 50's clinical record, including a psych consult dated September 16, 2022, failed to reveal Schizophrenia listed as a diagnosis. During an interview with Employee 2 on April 5, 2023, at 10:30 AM, she stated that Resident 50's MDS was coded incorrectly, as Resident 50 does not have a diagnosis of Schizophrenia. On April 5, 2023, at 11:36 AM, the NHA was made aware that Employee 2 stated Resident 50's MDS was coded incorrectly. No additional	F 0641		

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F 0641 SS=E	Continued from page 24 information was provided. Review of Resident 58's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and mild cognitive impairment (an early stage of memory loss in individuals who maintain the ability to independently perform activities of daily living). Review of Resident 58's physician orders revealed orders for Betadine Swabsticks External Swab 10 % (an antiseptic that is used to treat or prevent skin infection in minor cuts, scrapes, or burns), apply to between toes topically at bedtime and place lamb's wool between toes, dated March 3, 2023. Further review of this order revealed that Resident 58 had been receiving this treatment since April 5, 2022. Review of Resident 58's Quarterly MDS's (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs)	F 0641		

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F 0641 SS=E	Continued from page 25 with the assessment reference dates of June 24, 2022; September 23, 2022; December 16, 2022; and the Annual MDS with assessment reference date of January 18, 2023, revealed that the foot treatment was not included in Section M Skin Conditions. Further review of Resident 58's Quarterly MDS's with the assessment reference dates of June 24, 2022; September 23, 2022; and December 16, 2022, revealed in Section N Medications that Resident 58 had been documented as receiving a hypnotic for seven days during the assessment period. In addition, the Annual MDS with assessment reference date of January 18, 2023, revealed in Section N Medications that Resident 58 had received a hypnotic for seven days and an antibiotic for two days during the assessment period. Review of Resident 58's medication orders during the identified assessment periods revealed that Resident 58 had not received these medications.	F 0641		

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F 0641 SS=E	Continued from page 26 During an interview with Employee 2, on April 5, 2023, at 10:33 AM, Employee 2 confirmed that all these assessments were coded inaccurately. Review of Resident 65's clinical record revealed diagnoses that included sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues, potentially leading to the malfunctioning of various organs). Further review of Resident 65's clinical record revealed he was admitted to the facility on January 12, 2023, from the hospital, with a discharge plan to return to the independent living facility where he previously resided. Resident 65 was discharged from this facility back to independent living on January 23, 2023. Review of Resident 65's discharge MDS dated January 23, 2023, documented it was a planned discharge to the hospital with return not anticipated on January 23, 2023.	F 0641		

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F 0641 SS=E	Continued from page 27 Interview with Employee 2, on April 5, 2023, at 11:20 AM, revealed that the discharge MDS dated January 23, 2023, was marked in error. It was also revealed that Resident 65 was discharged back to independent living. Interview with the NHA on April 5, 2023, at 11:30 AM, revealed that, based on the information that was provided to him, Resident 65's discharge MDS was marked in error. 28 Pa. Code 211.5(f) Clinical records	F 0641		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 28 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Care plans corrected for the affected residents. 2. All residents have the potential to be affected by deficient practice. Initial audit of 20 random resident care plans to be conducted. 3. All care plan contributors will be reeducated on proper development and completion of comprehensive care plans. 4. Director of Nursing or Designee will audit 10 random comprehensive care plans weekly x four (4) weeks for compliance to ensure that therapeutic regimen has been captured and care plan is individualized. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: 05/23/2023 Status: APPROVED Date: 04/19/2023

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F 0656 SS=D	Continued from page 29 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 30 Based on observations, interviews, and record review, the facility failed to develop and/or implement a comprehensive person-centered care plan for four of 20 records reviewed (Residents 4, 6, 19, and 58). Findings include: Review of Resident 4's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 4's care plan failed to document a plan of care for dementia. Further review of Resident 4's clinical record revealed the care plan was reviewed on March 25, 2023. Interview with the Nursing Home Administrator (NHA) on April 5, 2023, at 10:30 AM, NHA revealed that the facility switched electronic medical record systems March 1, 2023; and resident	F 0656		

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F 0656 SS=D	Continued from page 31 records were being updated with their quarterly assessments. Review of Resident 6's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Observation in Resident 6's room on April 2, 2023, at 12:13 PM, revealed the Resident wearing oxygen running at 3 liters/minute (unit of measure). Review of Resident 6's physician orders revealed: oxygen at 3 Liters per minute via nasal cannula every shift, with a start date of March 9, 2023; oxygen tubing and humidifier changed every night shift every Monday, with a start date of March 13, 2023; oxygen tubing change weekly every night shift every Sunday, with a start date of April 2, 20/2/23. Further review of Resident 6's clinical record reveled they have been using oxygen since August 24, 2022; and physician orders included to change oxygen tubing and canister every week.	F 0656		

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F 0656 SS=D	Continued from page 32 Review of Resident 6's care plan failed to include a respiratory plan of care and use of oxygen. Interview with the Director Of Nursing (DON) on April 5, 2023, at 11:46 AM, it was revealed that Resident 6 should've had a respiratory care plan, and that the care plan was updated on April 5, 2023. Review of Resident 19's clinical record revealed diagnoses that included a nondisplaced fracture (a break in the bone when the bone fragments are not out of place) of the medial malleolus of right tibia (right ankle) and laceration without foreign body of the right lower leg. During an interview with Resident 19 on April 3, 2023, at 9:45 AM, Resident 19 indicated that they have a wound on their right leg and that it could be from their surgery. Further review of Resident 19's clinical record	F 0656		

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CHURCH OF GOD HOME INC STATE LICENSE NUMBER: **291602**	**801 NORTH HANOVER STREET CARLISLE, PA 17013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0656 SS=D	Continued from page 33 revealed an admission note dated February 21, 2023, at 5:54 PM, that stated, in part, that Resident 19 had a cast on their right ankle. Review of an additional progress note dated February 27, 2023, at 3:37 PM, indicated Resident 19 had their cast removed at their orthopedic appointment, and wound care orders were given for the laceration on the right lower leg. Review of Resident 19's orders revealed an order to Cleanse right calf wound with NSS, pat dry, and apply Xeroform non-adherent dressing and kling wrap every evening shift, dated March 15, 2023. Review of Resident 19's care plan failed to include Resident 19's actual wound to their right lower leg. During an interview on April 5, 2023, at 10:46 AM, with the DON, the DON indicated that Resident 19's current wound should have been specifically identified on their care plan.	F 0656		

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F 0656 SS=D	Continued from page 34 Review of Resident 58's clinical record revealed that they were admitted to the facility on March 24, 2022, with diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and edema (build-up of fluid in the body's tissue). Observation of Resident 58 on April 2, 2023, at 10:07 AM, revealed that their bilateral lower extremities (legs and feet) were swollen. Review of Resident 58's physician orders revealed orders for Lasix Oral Tablet (Furosemide), give 20 mg by mouth one time a day related to heart failure, and apply Ace wraps at 0600 after Biofreeze (a topical menthol gel that provides penetrating pain relief for sore muscles and joints) and Remove at HS (bedtime), all dated March 5, 2023. Review of Resident 58's care plan failed to include their heart failure and edema issues. During an interview with the DON on April 5, 2023,	F 0656		

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F 0656 SS=D	Continued from page 35 at 10:46 AM, the DON confirmed that Resident 58's heart failure and edema were not care planned, but should have been since they were longstanding issues for Resident 58. He further indicated the care plan would be updated to reflect these concerns. 28 Pa. Code 211.11(d) Resident Care Plans	F 0656		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 36 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Medication/treatment removed from bedside of resident #58. 2. All residents have potential to be affected by deficient practice. Initial audit of all resident rooms to be conducted to ensure no medications/treatments left at bedside. 3. All licensed staff to be educated concerning medications/treatments storage. 4. Director of Nursing or designee to audit all resident rooms three times per week for two weeks then weekly for two weeks for compliance to ensure no medications/treatments at bedside. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0689 SS=D	Continued from page 37 Based on observations, clinical record review, and resident and staff interview, it was determined that the facility failed to ensure the resident environment is free from accident hazards for one of 20 residents reviewed (Resident 58). Findings Include: Review of Resident 58's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and mild cognitive impairment (an early stage of memory loss in individuals who maintain the ability to independently perform activities of daily living). Review of Resident 58's physician orders revealed orders for: Betadine Swabsticks External Swab 10 % (an antiseptic that is used to treat or prevent skin infection in minor cuts, scrapes, or burns), apply to between toes topically at bedtime and place lamb's wool between toes, dated March 3,2023. Further review of this order revealed that Resident 58 had	F 0689		

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F 0689 SS=D	Continued from page 38 been receiving this treatment since April 5, 2022. Continued review of physician orders revealed: Lotrisone External Cream 1-0.05 % (Clotrimazole w/ Betamethasone- a topical medication used to treat fungal infections of the feet, groin, or body), apply to bilateral upper extremities topically every 12 hours as needed for Rash, dated March 2, 2023. Further review of this order revealed that Resident 58 has had this order since March 24, 2022. There was no order noted that Resident 58 could self-administer these medications. Observation of Resident 58 in their room on April 2, 2023, at 10:17 AM, revealed a tube of Lotrisone (clotrimazole-betamethasone cream) 1-0.05% laying at the foot of the bed, along with a clear plastic bag that contained betadine-iodine swabs and an ivory colored material. Resident 58 indicated "they use it for my feet." Observation of Resident 58 in their room on April 3, 2023, at 10:09 AM, revealed the same items were still present at the foot of the bed, slightly covered	F 0689		

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F 0689 SS=D	Continued from page 39 by an afghan. Observation of Resident 58 in their room on April 4, 2023, at 8:48 AM, revealed the same items were still present at the foot of the bed, slightly covered by an afghan. Further review of Resident 58's clinical record revealed that on March 30, 2023, a Self-Administration of Medication evaluation had been completed which indicated the following about Resident 58: Not capable of storing medications in a secure location. Assistance required with opening/closing medication containers. Administration of medication by route: Not capable of administering eye drops/ointments. Not capable of administering topical medications (including patches). Not capable of administering ear drops. Not capable of administering inhalants or inhalers. Not capable of administering suppositories.	F 0689		

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F 0689 SS=D	Continued from page 40 Not capable of administering subcutaneous injections. Medication knowledge: Not capable of naming medication(s) and their prescribed use. Not capable of reading the labels for medication(s)/prescription(s). Not capable of identifying common side effects of medication(s). Not capable of stating what time medication(s) are to be taken. Not capable of stating the proper dosage for medication(s). Not capable of dispensing proper amount of medication(s). Not capable of documenting self-administration of medication(s). PRN medication(s) (as needed medications): Not capable of identifying situations requiring the administration of PRN medication(s). During an interview with Employee 1 on April 4, 2023, at 11:43 AM, when shown the tube of	F 0689		

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F 0689 SS=D	Continued from page 41 clotrimazole-betamethasone cream 1/0.05% laying at foot of bed, along with a clear plastic bag that contained betadine-iodine swabs and an ivory colored material; they indicated that Resident 58 receives this treatment in the evenings. When asked if these items should be in the Resident's room, Employee 1 stated "No, probably not." Employee 1 then removed the items from the room. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing on April 4, 2023, at 12:35 PM, the NHA indicated that these items should not have been left in Resident 58's room. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0689		
F 0695 SS=E		F 0695		

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F 0695 SS=E	Continued from page 42 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident #6 oxygen tubing and humidifier replaced and bottle dated. Resident #23 oxygen order obtained, oxygen tubing dated and infection control bag in place. Residents #35 and #45 had CPAP cleaning orders obtained, CPAP machines cleaned, and infection control bags in place. 2. All residents ordered oxygen and CPAP have the potential to be affected by deficient practice. Initial audit of all residents ordered oxygen and CPAP have potential to be affected. Initial audit of all residents on oxygen and CPAP conducted to ensure proper orders, equipment, and cleaning/infection control protocols in place. 3. All licensed staff to be educated on oxygen and CPAP policies and procedures. 4. Director of Nursing or designee will complete three (3) random audits of residents ordered oxygen or CPAP per week for two weeks then weekly for two weeks to ensure compliance. This plan of correction will be monitored until such time consistent substantial compliance	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0695 SS=E	Continued from page 43	F 0695	has been met. Findings of this audit to be reported to QAPI.	

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F 0695 SS=E	Continued from page 44 Based on review of facility policy review, record review, observations, and resident and staff interview it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for four of 20 residents reviewed (Residents 6, 23, 35, and 45). Findings include: Review of facility policy, titled "CPAP Cleaning" dated October 29, 2008, indicated: 1. Face Mask Cleaning Procedure- Facemask must be cleaned daily with soap and water. Let the face mask air-dry before putting the mask away. Do not use harsh chemicals on the mask because the mask will deteriorate and a proper seal will not be obtained for the resident. 2. Tubing Cleaning Procedure- Clean tubing weekly using soap and water. Fill a clean basin with warm soap and water and submerse tubing in the water. Rinse tubing well and let the tubing air-dry. If tubing is dirty or torn, new tubing must be obtained.	F 0695		

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F 0695 SS=E	Continued from page 45 Review of facility policy, titled "Oxygen Therapy", revised October 2000, read, in part, check physician orders for oxygen order, in an emergency situation, start oxygen at 2 liters/minute and increase until pulse oximeter is noted to be 90% or greater, or respiratory symptoms have improved. The nurse must contact physician once emergent situation is over or resident is stable to inform the physician of resident's status and obtain additional orders. Initiate treatment order for oxygen therapy outlining if treatment is required continuously or PRN (as needed) and indicate equipment changing and cleaning. The following portion of the policy was updated July 29, 2016, and read, in part, continuous and intermittent use oxygen with and without humidification, change cannula tubing every two weeks and humidifier weekly. Review of Resident 6's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs).	F 0695		

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F 0695 SS=E	Continued from page 46 Observation in Resident 6's room on April 2, 2023, at 12:13 PM, Resident 6 was wearing oxygen running at 3 liters/minute (unit of measure), the oxygen tubing was dated March 20, 2023, and the humidifier bottle wasn't date marked. Review of Resident 6's physician orders revealed: oxygen at 3 Liters per minute via nasal cannula every shift, with a start date of March 9, 2023; oxygen tubing and humidifier changed every night shift every Monday, with a start date of March 13, 2023; oxygen tubing change weekly every night shift every Sunday, with a start date of April 2, 2023. Further review of Resident 6's clinical record reveled they have been using oxygen since August 24, 2022; and physician orders included to change oxygen tubing and canister every week. Interview on April 4, 2023, at 12:23 PM, with Employee 2 (Registered Nurse), revealed oxygen tubing is changed every Sunday on night shift.	F 0695		

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F 0695 SS=E	Continued from page 47 Observation in Resident 6's room on April 2, 2023, at 12:25 PM, with Employee 2, Resident 6's oxygen tubing was dated March 20, 2023, and the humidification bottle wasn't date marked. Interview on April 4, 2023, at 12:25 PM with Employee 2, it was revealed that Resident 6's oxygen tubing was not changed, and it should have been changed on Sunday March 26, 2023. Interview on April 4, 2023, at 2:30 PM the Nursing Home Administrator (NHA) was made aware that Resident 6's oxygen tubing was dated March 20, 2023, and the humidifier wasn't dated. No further information was provided. Review of Resident 23's clinical record revealed he was admitted to the facility on March 26, 2023. Further clinical record review revealed diagnoses that included: disorientation, hypertensive heart disease (heart problems that occur because of high blood pressure), cognitive communication deficit (an impairment in organization/thought organization,	F 0695		

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F 0695 SS=E	Continued from page 48 sequencing, attention, memory, planning, problem-solving, and safety awareness). Observation in Resident 23's room on April 2, 2023, at 1:21 PM, Resident 23 wasn't wearing oxygen, the concentrator wasn't running, the tubing was observed to be on the floor and not in an infection control bag, and the tubing wasn't labeled with a date. Interview with Resident 23 on April 2, 2023, at 1:21 PM, revealed that he had used oxygen several days ago, but doesn't use it continuously. Further review of Resident 23's clinical record revealed on March 28, 2023, Resident 23 was short of breath and was administered oxygen at 2 liters/minute due to oxygens saturation of 84% on room air. On March 29, 2023, on day shift, Resident oxygen saturation was 99% on 2 liters/minute of oxygen, and on evening shift oxygen saturation was 92% on	F 0695		

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F 0695 SS=E	Continued from page 49 room air (was not wearing oxygen). Review of Resident 23's physician orders: oxygen at 2 liters/minute to maintain saturation >90%, as needed for hypoxia, with a start date April 4, 2023; oxygen tubing and humidifier change every night shift every Sunday, with a start date April 4, 2023; and ensure oxygen tubing is in antimicrobial bag every shift, monthly every shift, and every night shift starting on the 9th and ending on the 10th every month, with a start date of April 9, 2023. The facility failed to obtain an oxygen order for Resident 23, and continue to administer oxygen without an order 24 hours after initiated emergently. Facility failed to ensure oxygen tubing was kept clean and sanitary. During an interview in April 4, 2023, at 2:30 PM, NHA was made aware that Resident 23 was administered oxygen without a physician order, that the tubing was not dated, and was observed to be on the floor. No further information was provided.	F 0695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=E	Continued from page 50 Review of Resident 35's clinical record revealed diagnoses that included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 35's physician's orders revealed an order for Continuous Positive Airway Pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while one sleeps) for sleep at 12-18 centimeters of H2O (water) via CPAP face mask every evening shift, dated March 5, 2023. There were no orders noted for the cleaning of the CPAP face mask or tubing. Further review of Resident 35's clinical record revealed that they had been using the CPAP since November 9, 2022. Observation of Resident 35 on April 2, 2023, at 11:16 AM, revealed their CPAP mask laying on the	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	04/05/2023

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F 0695 SS=E	Continued from page 51 floor beside their bed, unbagged. Observation of Resident 35 on April 3, 2023, at 10:06 AM, revealed their CPAP mask laying on top of the CPAP machine on the bedside stand, unbagged. Observation of Resident 35 on April 4, 2023, at 8:35 AM, revealed their CPAP mask laying on their bed, unbagged. During an interview with the NHA and Director of Nursing (DON) on April 4, 2023, at 12:38 PM, the above concerns were shared for follow-up. During a follow-up interview with the NHA and DON on April 5, 2023, at 09:07 AM, the DON confirmed that Resident 35 had no orders for cleaning of their CPAP and that the orders for cleaning should have been obtained at the same time the order was given for the CPAP. He indicated that the orders would be updated to reflect the cleaning of the CPAP. He further indicated that the mask	F 0695		

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F 0695 SS=E	Continued from page 52 should have been bagged when not in use and that an infection control bag had been placed at the bedside for this purpose. Follow-up observation of Resident 35 on April 5, 2023, at 11:45 AM, revealed Resident 35's CPAP mask was stored in an infection control bag at bedside. Review of Resident 45's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep) and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 45's physician orders for Continuous Positive Airway Pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while one sleeps) continue with current settings at 8.0, dated March 9, 2023; Cleanse humidification container and mask with mild soap and water and dry weekly every night shift	F 0695		

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F 0695 SS=E	Continued from page 53 every Sunday, dated March 4, 2023; and Change CPAP mask and fine filter (light blue) every 14 days (family to provide supplies), dated February 28, 2023. Further review of Resident 45's clinical record revealed that they had been using the CPAP since May 24, 2022. Observation of Resident 45 on April 2, 2023, at 10:47 AM, revealed a CPAP machine on their bedside stand with the mask hanging on the side of the bedside stand, still connected to tubing, attached to the machine, and unbagged. Observation of Resident 45 on April 3, 2023, at 10:00 AM, revealed their CPAP mask hanging on bedside stand, still connected to tubing, attached to machine, and unbagged. Observation of Resident 45 on April 4, 2023, at 10:04 AM, revealed their CPAP mask laying on top of the CPAP machine, still connected to tubing,	F 0695		

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F 0695 SS=E	Continued from page 54 attached to machine, and unbagged. During an interview with the NHA and DON on April 4, 2023, at 12:35 PM, the above concerns were shared for follow-up. During a follow-up interview with the NHA and DON on April 5, 2023, at 09:07 AM, the DON confirmed that he was in process of reviewing facility policy to determine exact cleaning method. He further indicated that infection control bags had been placed in Resident 45's room to put the mask in when not in use. He confirmed that the infection control bags should have been in place. A follow-up observation of Resident 45 on April 5, 2023, at 10:17 AM, revealed that Resident 45's CPAP mask was stored in an infection control bag at bedside. 28 Pa code 211.12(d)(1)(2) Nursing Services	F 0695		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 55 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	1. Annual performance evaluations for NAs #8, #9, #10, #11, and #12 have been completed. 2. All residents have potential to be affected by deficient practice. No performance evaluations for NAs have been completed during the survey period. 3. Policy and procedure for annual performance evaluations to be developed. Licensed nurses to be educated concerning completion of annual performance evaluations. 4. Human Resource Director or Designee to have NA performance evaluations completed within six weeks. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0730 SS=E	Continued from page 56 Based on personnel file review and staff interview, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for five of five nurse aides reviewed (Nurse Aides 8, 9, 10, 11, and 12). Findings Include: Review of Nurse Aide (NA) 8's submitted employee documentation revealed that NA 8 was hired on May 2, 2016. Review of available documentation revealed no annual performance evaluation for NA 8. Review of NA 9's submitted employee documentation revealed that NA 9 was hired on May 6, 2019. Review of available documentation revealed no annual performance evaluation for NA 9. Review of NA 10's submitted employee	F 0730		

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F 0730 SS=E	Continued from page 57 documentation revealed that NA 10 was hired on November 7, 2016. Review of available documentation revealed no annual performance evaluation for NA 10. Review of NA 11's submitted employee documentation revealed that NA 11 was hired on May 2, 2016. Review of available documentation revealed no annual performance evaluation for NA 11. Review of NA 12's submitted employee documentation revealed that NA 12 was hired on December 5, 2014. Review of available documentation revealed no annual performance evaluation for NA 9. During an interview with the Nursing Home Administrator on April 4, 2023, at approximately 1:00 PM, it was revealed that the facility did not	F 0730		

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F 0730 SS=E	Continued from page 58 perform annual performance evaluations for Nurse Aides. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.20(a)(c) Staff development	F 0730		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 59 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. Identified items immediately discarded. Expired pH strips were disposed of and replaced. Drain pipes in Faith wing and Love wing pantries repaired. Dietary staff placed hair nests properly. 2. The facility has determined that all residents who consume food by mouth have the potential to be affected by the alleged deficient practice. 3. All nursing and dietary staff will be in-serviced on food labeling, dating, and storage. Dietary staff to be educated concerning proper hair restraints. 4. The Nursing Home Administrator or designee will conduct random audits of pantries and kitchen weekly for four (4) weeks to ensure compliance. Maintenance or designee will audit drain pipes weekly for four (4) weeks. This plan of correction will be monitored until such time consistent substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/19/2023**

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F 0812 SS=E	Continued from page 60 Based on observation, review of facility policy, and interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen and in two of two nourishment pantries. Findings include: Review of facility policy, titled "Employee Hair Restraints", no date, read, in part, food employees shall wear hair restraints such as hats, hair coverings, or nets to effectively keep their hair from contacting food. Review of facility policy, titled "Use and Storage of Food Brought in by Family or visitors", revised April 3, 2023, read in part, food brought in must be labeled with content and date. Review of facility policy, titled "Food Safety Management Systems", revised December 6, 2022, read, in part, date cartons, cases, and boxes with "date received". Food prepared in the food	F 0812		

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F 0812 SS=E	Continued from page 61 establishment and held longer than the subsequent meal period must be marked to indicate the date or day by which the food is to be consumed or discarded when held at 41 degrees Fahrenheit for a maximum of seven days. Observation in the walk-in freezer on April 2, 2023, at 9:48 AM, the following items were not date marked: one bag of cream puffs, and one quarter yellow sheet cake. Interview with Employee 5 (Food Service Supervisor), on April 2, 2023, at 9:48 AM, revealed that the bag of cream puffs and the yellow cake should be marked with a date. Observation in the walk-in refrigerator on April 2, 2023, at 9:49 AM, the following items were not date marked: two sheet trays of portioned cherry crisp; one half pan pulled pork; one pan that contained pork shoulder; one quarter pan of chipped beef; two 5 pound (unit of measure) boxes and one 5 pound bag of thawed diced chicken; four	F 0812		

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F 0812 SS=E	Continued from page 62 trays of thawed Danish; four pounds of sliced white American cheese; two pounds of thawed Salisbury steak; one open 5 pound bag of diced onions; one open container of diced green peppers; two open bags of parsley; one open 5 pound bucket of dill pickle spears, dated as delivered September 23, 2022, and the bucket contained a speckled black substance around the upper quarter perimeter of the container; one quarter pan of sliced scrapple; one and a quarter pounds of slices Swiss cheese; and 30 pounds of thawed chicken breasts. Interview on April 2, 2023, at 9:50 AM, with Employee 5, revealed that the cherry crisp was to be served for lunch that day; the pulled pork and the pork shoulder were served on Saturday and will be put in the freezer; the chipped beef was pulled from the freezer on Thursday and served Saturday; the diced chicken was pulled from the freezer on Friday; the Danish should be date marked when pulled from the freezer; the American cheese should be date marked when opened; the Salisbury steak was served the other day and should be thrown	F 0812		

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F 0812 SS=E	Continued from page 63 away; the diced onions, green peppers, and parsley should be dated when opened; the dill pickles should be discarded; the scrapple was served for breakfast the other day and should be discarded; the Swiss cheese should be dated when opened, and the chicken breasts were pulled from the freezer April 1st, 2023, and should be dated when pulled from the freeze. Observation in the kitchen on April 2, 2023, at 10:18 AM, revealed the following: one bulk bin containing flour had a scoop stored inside the bin, and the bin wasn't labeled or date marked; one bulk bin containing sugar had a scoop stored inside the bin, and the bin wasn't labeled or date marked; and one half pan contained five wrapped sugar cookies and one wrapped blueberry muffin that wasn't date marked. Interview on April 2, 2023, at 10:20 AM, with Employee 5 revealed that the bulk bins of flour and sugar were recently cleaned and filled, and the scoop shouldn't be stored inside. It was also	F 0812		

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F 0812 SS=E	Continued from page 64 revealed that the sugar cookies and blueberry muffin were left over from a recent meal and should be date marked or discarded. Observation on April 2, 2023, at 10:15 AM, revealed that the pH test strips at the three-compartment sink contained an expiration date of June 2022. Interview with Employee 5 revealed he wasn't aware that the pH strips contained an expiration date. It was also revealed that all containers of pH strips in the facility were expired. Observation in the Faith unit nourishment pantry refrigerator on April 2, 2023, at 10:30 AM, revealed two 32 ounce (oz- unit of measure) containers of prune juice were open with contents partially removed and didn't contain an open or use by date. Observation in the Faith unit nourishment pantry freezer on April 2, 2023, at 10:31 AM, revealed	F 0812		

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F 0812 SS=E	Continued from page 65 one plastic cup from a commercial fast food restaurant contained a light brown frozen substance that wasn't labeled with a name or date. Interview on April 2, 2023, at 10:35 AM, with Employee 15 (Registered Nurse), revealed the prune juice should be date marked when opened. It was also revealed that the aforementioned cup in the freezer should've been marked with a resident name and date. Further observation in the Faith wing nourishment pantry on April 2, 2023, at 10:29 AM, revealed the drain pipe from the ice machine was below the grade of the floor drain and there was no air gap. Observation with Employee 7 (Director of Maintenance), on April 4, 2023, at 8:52 AM, revealed the drain pipe from the ice machine in the Faith Nourishment pantry was below the top of the drain; there wasn't an air gap. Interview with Employee 7, April 4, 2023, at 8:52	F 0812		

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F 0812 SS=E	Continued from page 66 AM, it was revealed that the drain pipe was propped up by a wooden block which had moved, leaving no air gap. Employee 7 stated that maintenance would repair the drainpipe. Observation in the Love unit nourishment pantry with Employee 3 (Registered Nurse), on April 2, 2023, at 10:45 AM, the following items were not date marked: two 32 oz containers prune juice; one 42 oz container nectar thick apple juice; one 42 oz container honey thick apple juice; one 42 oz container honey thick orange juice; 4 oz container of chocolate pudding open with contents partially removed; 8 oz cup of thickened ice tea, with no resident name; one plastic container of pulled pork, with no resident name. Interview with Employee 3 on April 2, 2023, at 10:48 AM, revealed the aforementioned items should be dated when opened, and resident food should be labeled with a name and date. Further observation in the Love wing nourishment	F 0812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 67 pantry on April 2, 2023, at 10:48 AM, the drainpipe from the ice machine was below the top grade of the floor drain, there was no air gap. Observation with Employee 7, on April 4, 2023, at 8:55 AM, the drain pipe from the ice machine in the Love Nourishment pantry was below the top of the drain, there wasn't an air gap. Interview with Employee 7, on April 4, 2023, at 8:55 AM, it was revealed that the drainpipe was propped up by a small section of plastic pipe and it had moved, leaving no air gap. Employee 7 stated that maintenance would repair the drainpipe. Interview with the Nursing Home Administrator (NHA) on April 3, 2023, at 2:30 PM, reviewed the concerns regarding labeling and date marking of food items in the kitchen, and nourishment pantries. It was revealed that food items should be labeled and dated per policies. Interview with the NHA on April 4, 2023, at 12:40	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: __00_____ B. WING: _____	04/05/2023

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F 0812 SS=E	Continued from page 68 PM, to inform of the concern with the lack of an air gap for the ice machines in the nourishment pantries; it was revealed that the repairs were being completed that day. Observation during lunch meal service on April 3, 2023, at 12:30 PM, in the kitchen, Employees' 13 and 14 hair was not fully covered with a hair net. Interview with Employee 6 on April 3, 2023, at 12:35 PM, revealed that staff should have hair nets on that cover all of their hair. Employee 6 instructed Employees 13 and 14 to ensure their hair is covered by the hair net. Interview with the NHA on April 4, 2023, at 12:40 PM, to inform of the concern with the two employees without appropriate hair covering during meal service; no further information was provided. 28 Pa code 211.6(b)(d) - Dietary Services	F 0812		

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P 1625	§ 211.2(b) Physician services. (b) The facility shall have available, prior to or at the time of admission, resident information which includes current medical findings, diagnosis and orders from a physician for immediate care of the resident. The resident's initial medical assessment shall be conducted no later than 14 days after admission and include a summary of the prior treatment as well as the resident's rehabilitation potential. This REGULATION is not met as evidenced by:	P 1625	1. Resident #39 evaluated by physician. 2. All residents have potential to be affected by deficient practice. An initial audit of all admissions over past 30 days to be conducted for compliance. 3. Physicians will be educated regarding physician evaluation after admission/readmission. 4. All admissions/readmissions to be audited for timely physician evaluation for six weeks until substantial compliance has been met. Findings of this audit to be reported to QAPI.	Completion Date: 05/23/2023 Status: APPROVED Date: 04/19/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1625	Continued from page 1 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a physician assessment was conducted after readmission for one of three resident's reviewed for hospitalization (Resident 39). Findings include: Review of Resident 39's clinical record on April 3, 2023, at approximately 10:00 AM, revealed diagnoses of dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and congestive heart failure (disease process of the heart that results in decreased ability of the heart to efficiently pump blood to the body). Review of Resident 39's clinical record revealed that on February 26, 2023, Resident 39 was sent to an emergency room for evaluation after a change in condition.	P 1625		

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P 1625	Continued from page 2 Review of a progress note documented on February 26, 2023, at 10:33 AM, revealed that Resident 39 was admitted to the hospital for the diagnosis of aspiration pneumonia. Review of Resident 39's clinical record revealed that Resident 39 was readmitted to the facility on March 6, 2023. Review of Resident 39's clinical record revealed no physician evaluation after the March 6, 2023 readmission. During a staff interview on April 5, 2023, at approximately 10:40 AM, Nursing Home Administrator (NHA)confirmed that there was no physician evaluation performed for Resident 39 after the March 6, 2023 readmission. During the staff interview, NHA revealed it was the facility's expectation that a physician evaluation would have been performed after the March 6, 2023 readmission.	P 1625		

Certified End Page

CHURCH OF GOD HOME INC

STATE LICENSE NUMBER: 291602

SURVEY EXIT DATE: 04/05/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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